STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G127	A. BUILDING _____ B. WING _____	09/26/2008

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MY OWN PLACE	4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from September 24, 2008 through September 26, 2008. The survey was initiated using the fundamental survey process. A random sample of two clients were selected from a population of three males with various degrees of disabilities. The findings of this survey were based on observations at the group home, two day programs, interviews with the clients at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident reports.	W 000	Received 10/21/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure that person making entries in the client's record dated and signed it for two of the two cleints included in the sample. (Clients #1 and #2) The findings include: 1. Observations of the medication administration on September 24, 2008, at 4:50 PM revealed that Client #1 received Lactulose 30 ml. Record verification of the physician orders dated September 2008 revealed no physician's signature. Further review of the client's physician order revealed no primary care physician signature on August and June 2008 orders. 2. Observations of the medication administration	W 114	W114 1. Though My Own Place policy states that physician orders are to be signed at least every ninety dates, in order to promote best practices, in the future, the RN for facility as part of her monthly reviews will ensure that the primary care physician has signed all current physician orders. In addition a copy of the signed physician orders will be submitted to the main office for the Director or Nursing's review and filing. (see attached nursing policy)	9/26/08 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 10/20/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 114	Continued From page 1 on September 24, 2008 at 5:02 PM revealed that Client #2 received Zantac 150 mg, Calcarb with Vitamin D, Docusate Sodium, etc..... Record verification of the physician orders dated September 2008 revealed no physician's signature. Further review of the client's physician order revealed no primary care physician signature on August and June 2008 orders.	W 114	2. Although the primary care physician has reviewed the medical records of the individuals in the home on a monthly basis as evident from his monthly notes, in order to promote best practices, In the future, the RN for the facility will ensure that the PCP signs all physician orders and copies of the signed orders will be submitted to the main office for the Director of Nursing review. (see attached monthly physician notes for resident#1.)	9/26/08 and ongoing
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services met the needs of two of the two clients included in the sample. (Clients #1 and #2) The findings include: 1. On September 24, 2008 at 5:25 PM, Client #1 was observed eating dinner using a built up handle tablespoon. Interview with the day program staff on September 25, 2008, at 1:00 PM revealed that the client uses a regular plastic teaspoon during meals. Interview with the Qualified Mental Retardation Professional (QMRP), direct care staff and the Registered Nurse (RN) on September 25, 2008 at approximately 3:00 PM indicated that the client eats with a built up handle tablespoon to eliminate spillage. During the environmental inspection on September 26, 2008 revealed that the client had three built up handle spoons in the cutlery draw. Record verification of the Occupational Therapy assessment dated December 27, 2006 revealed	W 120	W120 On September 25, 2008 the QMRP took resident#1's built up spoon to his day program along with ISP containing the OT report specifying the use of the built up spoon. Additionally the QMRP has been conducting weekly checks during mealtime, to ensure that the spoon is being utilized at the day program. In the future, the QMRP will include Adaptive equipment checks as part of her monthly day program report. (See attached monthly day program report)	9/25/08 and ongoing

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W 120	Continued From page 2 that the client should use built up spoons to minimize spillage during meals. Further interview with the QMRP indicated that she would contact and provide the day program with the appropriate adaptive feeding equipment. 2. On September 24, 2008 at 5:25 PM, Client #2 was observed eating dinner using a built up tablespoon, high sided plate, cup with handles and an elevated plate riser. Observations at Client #2's day program on September 26, 2008, at 11:20 AM revealed the client was being fed his lunch. The treatment staff was using a built up handle spoon, scoop plate and cup with lid. Interview with the treatment staff indicated that the client should have an elevated plate riser. Further interview with the treatment staff revealed that the client was sitting at a high table until the residential provider provided the elevated tray. According to the treatment staff, he informed the Program Director approximately two weeks ago. Review of the client's record revealed no evidence of such communication. Review of the Client #2's feeding protocol dated June 18, 2006 on September 26, 2008 at 12:00 PM revealed the following adaptive feeding equipment: built up handle spoon, scoop plate, elevated tray and cup with lid. Record verification of the Occupational Therapy assessment dated December 5, 2006 revealed that the client should use the following adaptive feeding equipment: built up handle spoon, scoop plate and cup with handle during meals. Interview with QMRP on September 26, 2008 at 3:00 PM revealed that she would contact and provide the day program with the appropriate adaptive feeding equipment.	W 120	2. Resident# 2's elevated plate riser was taken to the day program on September 26, 2008 along with a copy of the most recent ISP with OT recommendations for adaptive equipment. Additionally the QMRP has been conducting weekly checks during mealtimes, to ensure that all adaptive equipment is being utilized at the day program. In the future, the QMRP will include Adaptive equipment checks as part of her monthly day program report.	9/26/08 and ongoing
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS	W 124		

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W 124	Continued From page 3 The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for two of the two clients included in the sample. (Clients #1 and #2) The findings include: 1. The facility failed to provide evidence that informed consent was obtained from Client #1 and/or her legal guardian for sedations given during medical appointments. Review of Client #1's records on September 25, 2008, at approximately 2:47 PM revealed a written physician order dated December 10, 2007 that documented the client received Ativan 2 mg one hour before her ENT appointment. It should be noted that interview with the Registered Nurse (RN) on September 25, 2008 revealed the medications were administered to address behaviors during medical appointments and further verified that the sedations were administered. Interview with the Qualified Mental Retardation	W 124	W124 1. As of 10/2/08 M.O.P has revised its policy to ensure that all procedures requiring sedation are preceded by consent from the individual's legal guardian. In the future, M.O.P will ensure that consents are received prior medical appointments and that the consents are maintained in the individual's medical record. (See attached revised policy)	10/2/08 and ongoing

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W 124	Continued From page 4 Professional (QMRP) on September 25, 2008 at approximately 2:00 PM revealed that Client #1 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on September 25, 2008 at 3:20 PM through review of Client #1's psychological assessment dated December 6, 2007. According to the assessment, Client #1 "does not evidence the capacity to make decisions on her behalf in treatment/habilitation, on going medical care, residential placement, and financial matters." Additionally, the QMRP revealed that Client #1 did not have a legal guardian but did have involved family members. At the time of the survey, however, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative for the use of the aforementioned sedations. 2. The facility failed to provide evidence that revealed Client #2's legal guardian had been informed of recommended sedations prior to administering them. Review of Client #2's medical record on September 25, 2008 at approximately 4:00 PM revealed the following written physician's orders: March 5, 2008 - Ativan 2 mg by mouth one hour prior to dental evaluation. Review of the corresponding Medication Administration Record (MAR) for March 2008 verified the sedation was administered on March 17, 2008. January 7, 2008 - Chloral Hydrate 500 mg by mouth prior to medical appointment. Review of corresponding MAR for January and February 2008 revealed the sedation was administered on	W 124	2. M.O.P has revised its policy to ensure that all guardians are notified in writing of procedures requiring sedation. Additionally, M.O.P has developed a consent form that provides the guardian with information about the procedure, medication used for sedation as well as any possible side effects. In the future, M.O.P will ensure that consents are received prior medical appointments and that the consents are maintained in the individual's medical record. (see attached informed consent form)	10/2/08 and ongoing

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W 124	Continued From page 5 February 6, 2008. December 10, 2007 - Ativan 2 mg by mouth prior to dental appointment. Review of corresponding MAR for January 2008 revealed the sedation was administered on January 22, 2008. Interview with the Qualified Mental Retardation Professional (QMRP) on September 26, 2008 at approximately 11:30 AM revealed Client #2 was not capable of giving informed consent for the use of medications and habilitation services. The QMRP's statement was verified on September 26, 2008 at 12:00 PM through review of Client #2's Psychological Assessment dated September 23, 2007. According to the assessment, Client #1 was "not able to make independent decisions concerning his treatment plan, financial affairs, living arrangements, or day placement." The QMRP revealed the client did not have a legal guardian to assist him in decision making. The QMRP further revealed that Client #1 had an involved family member (sister). At the time of the survey, however, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative for the use of the aforementioned sedations. Interview with the facility's RN and continued review of the client's record on September 26, 2008 confirmed the client received the sedation for non-compliance with the aforementioned medical appointments.	W 124		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of	W 140		

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W 140	Continued From page 6 clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of clients personal funds for one of the three clients in the sample. (Client #1) The finding includes: Review of Client #1's financial record was conducted on September 26, 2008 at 1:00 PM. The bank statements were reviewed from December 2007 through July 2008 and revealed the following withdrawals: - July 14, 2008 in the amount of $118.17. There were receipts totaling 45.14; - July 18, 2008 in the amount of $25.00; and - July 21, 2008 in the amount of $34.00. At the time of the survey, the facility failed to ensure a complete accounting of Client #1's personal funds by proving evidence that justified the aforementioned withdrawal.	W 140	W 140 1. M.O.P policy states that resident accounts are to be reconciled on a monthly basis. However due to the fact that the resident manager was in a severe accident at the time of the survey, we were unable to obtain information about the missing receipts for the resident#1, during the month of July. In the future however all resident funds will be thoroughly and completely reconciled prior to the release of any additional monies and the financial records will be audited on Quarterly basis by the QMRP as part of her Quarterly review. (See attached financial policy)	11/15/08 and ongoing
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by:	W 159		

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W 159	Continued From page 7 Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The QMRP failed to ensure that day program was provided with current dietary order. [See W120] 2. The facility failed to ensure each client's individual program plan (IPP) included training in activities of daily living skills in both formal and informal setting. [See W242] 3. The QMRP failed to ensure that clients received continuous active treatment to support achievement of IPP objectives identified by the interdisciplinary team. [See W249] 4. The QMRP failed to review and revise the IPP once the client had successfully completed an objective identified in the IPP. [See W255]	W 159	W159 1. On 10/15/08 the QMRP provided all day programs with current dietary orders for each individual in the home. In the future, the QMRP will ensure that each program has current orders during the monthly day program monitoring process. 2. On 10/15/08 the QMRP has ensured that each individual's IPP was revised to ensure informal training of activities of daily living including personal hygiene care. (See attached personal care sheet.) In the future, the QMRP will monitor these activities of daily living weekly and detail progress in monthly notes. 3. The QMRP has reviewed all IPP goals in the most recent ISP's for the individuals in the home to ensure that the individuals are being appropriately supported in achieving the IPP goals. On 10/19/08 the QMRP has re-trained the staff in the home on the appropriate implementation and documentation of the goals identified by the interdisciplinary team. (See attached sign-in sheet and agenda) In the future, the QMRP will complete weekly systematic monitoring staff's implementation of IPP goals to ensure appropriate support is being given to the individual to achieve maximum outcomes. The QMRP will give feedback on her observations and any staff training conducted during her quarterly reviews. 4. The QMRP will revise all IPP goals by 11/20/08 as this is the ISP renewal date for the individuals in the home, to reflect achievements and progress. In the future, the QMRP will monitor all IPP goals and make revisions as goals have been achieved or deemed unattainable. Additionally, the QMRP will reflect the progress of these goals in her quarterly report.	10/15/08 and ongoing 10/15/08 and ongoing 10/19/08 and ongoing 11/20/08 and ongoing
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, interview and the record review, the facility staff failed to demonstrate competency in the implementation of each clients individual program plan, for one of the two clients included in the sample. (Client #1)	W 194		

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W 194	Continued From page 8 The finding includes: On September 24, 2008 at 4:10 PM, Client #1 arrived home from day program in a wheelchair. At 4:15 PM, a direct care staff was observed removing the client's shoes. At 4:18 PM, the client was observed walking to his bedroom using a roller walker. The client's feet were observed in a horizontal position. Interview with the direct care staff indicated that once the client came home from day program he utilized his roller walker around the house. Review of Client #1' s record on September 25, 2008 at approximately 3:00 PM revealed a Physical Therapy (PT) assessment dated December 12, 2007. According to the assessment, the consultant recommended that the client should wear shoes during "ALL" ambulation. Further interview with the direct care staff indicated that the client usually refused to walk in his shoes. Interview with the Qualified Mental Retardation Professional (QMRP) on September 25, 2008 verified the information documented by the consultant and indicated that the client should wear shoes during all ambulation. At the time of the survey, the facility failed to ensure staff kept shoes on Client #1 during ambulation as recommended by the PT.	W 194	W 194 1. Resident#1 has expressed discomfort when ambulating with shoes around the house. As a result the PT has re-evaluated the individual on 10/4/08 to ensure safety if he desires to ambulate without his shoes in the home. (See attached PT report) In the future however, the QMRP will ensure, staff appropriately implement all programs by conducting weekly systematic monitoring and training of staff implementation of IPP goals and recommendations to ensure appropriate support is being given to the individual to achieve maximum outcomes. In cases where there is concern about the implementation of the recommendations, the QMRP will notify the professional that developed the program within 72 hours to request a reevaluation or modification as deemed necessary.	10/4/08 and ongoing
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated	W 242		

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W 242	Continued From page 9 that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each client's individual program plan (IPP) included training in activities of daily living skills in both formal and informal setting for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. On September 24, 2008, at 4:20 PM, a direct care staff was observed preparing dinner. At 5:35 PM, the direct care staff was observed putting the dishes in the dishwasher after the dinner. Client #1 was observed going to the living room area and having a seat on the sofa. Interview with the direct care staff indicated that Client #1 does not participate in meal preparations or clean up. Review of the client's Nutritional assessment dated December 18, 2007 on September 25, 2008 at 3:30 PM revealed a recommendation for the client to participate in meal preparation. Further review of the client's IPP dated December 18, 2007 failed to identify a meal preparation program. 2. Observations on September 24, 2008 at 5:45 PM, Client #2 completed his dinner. The client propelled his wheelchair to the living room where he watched television until 6:45 PM. Review of Client #2's medical record revealed a dental consultation dated March 17, 2008 and October 12, 2006. The consultation indicated that the client had periodontitis disease, heavy plaque and calculus deposits. The dentist recommended that	W 242	W242 1. On 10/19/08 the QMRP has implemented a meal preparation program for individual #1 as well as #2 based on their level of independence. Additionally, the QMRP on 10/19/08 has conducted trainings on implementation and documentation of these new programs. In the future, the QMRP will continue to assess individual's strength by completing ABS-RC2 assessments annually, and accordingly develop activities and programs that promote independence and positive outcomes for each resident. 2. On 10/19/08 the QMRP has implemented a hygiene monitoring program to promote optimal oral health for all individuals in the home. The QMRP has trained staff on the implementation and documentation of the program and will monitor data and implementation on a weekly basis. In the future the QMRP will ensure that all specialist recommendations are immediately followed-up on and implemented to promote optimum health. (See attached Hygiene Maintenance Chart)	10/19/08 and ongoing 10/19/08 and ongoing

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W 242	Continued From page 10 the client brush his teeth three times per day (after each meal). There was no evidence that the direct care staff encouraged the client to brush his teeth. Review of the IPP dated November 18, 2007 failed to identified a toothbrushing program.	W 242		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide continuous active treatment for one of the two clients included in the sample. (Client #1) The finding incudes: During the medication administration on September 24, 2008 at 5:02 PM, Client #1 was observed punching medication from the bubble pack into a medication cup with physical assistance from the Trained Medication Employee (TME). The TME put the medication cup on the table. The client was observed picking up the medication cup and water and drinking independently. Interview with the TME indicated that the client participates well in the self medication program.	W 249	W 249 On 10/17/08 the RN along with the input of direct care staff and the QMRP, has completed all self medication assessments for the individual's residing in the facility. The results of the assessment will be discussed and integrated in to the upcoming ISP's on November 20, 2008. (See attached assessments) In the future the RN will evaluate the individual's strengths Quarterly in effort maximize participation during the delivery of their medications.	11/23/08 and ongoing

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W 249	Continued From page 11 Review of the Client #1's Individual Program Plan (IPP) dated December 18, 2007 revealed a program objective which stated, "With staff assistance, [the client] will review his list of medications and their purpose, weekly." There was no evidence that the client listed his medications during the medication pass observation.	W 249		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on staff interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the client had successfully completed an objective identified in the IPP for one of the three clients in the sample. (Client #1) The finding includes: Review of Client #1's IPP dated December 18, 2007 on September 25, 2008 at approximately 3:00 PM revealed a program objective which stated, "With staff assistance, [the client] will exit the home in less than three minutes during a fire drill for four consecutive sessions". Review of the QMRP quarterly review dated July 10, 2008 revealed that the client met the established	W 255	W255 Based on information gathered from the program data sheets for resident# 1, he has met the criteria of exiting the home with staff assistance in less than three minutes during a fire drill for four consecutive sessions. However the IDT team decided to continue this goal for maintenance to be reevaluated during the upcoming ISP meeting on November 20, 2008. In the future the QMRP will ensure that all program outcomes are monitored monthly to and updated or revised based on achievement of goals to promoted maximum independence.	11/20/08 and ongoing

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	09G127	A. BUILDING _____ B. WING _____	09/26/2008

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W 255	Continued From page 12 criteria for the period of April 2008 through June 2008. Further review of the data sheets indicated that the client met the established criteria since May 2008. There was no evidence that the QMRP revised the program.	W 255		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for two of the three clients included in the sample. (Clients #1 and #2) The finding includes: The facility failed to ensure written informed consent was obtained from Clients #1and #3's legal guardian prior to administering sedations. [Cross-refer to W124]	W 263	W 263 As of 10/2/08 M.O.P has revised its policy to ensure that all procedures requiring sedation are preceded by consent from the individual's legal guardian. In the future, M.O.P will ensure that consents are received prior medical appointments and that the consents are maintained in the individual's medical record. (See attached revised policy)	10/2/08 and ongoing
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.	W 325		

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W 325	Continued From page 13 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide routine laboratory testing as determined necessary by the physician for one of two clients included in the sample. (Client #1) The finding includes: Review of Client #1's current physician order on September 25, 2008 at approximately 2:00 PM revealed an order for the client to receive a chest x-ray every three years. Further review of the record revealed a chest-ray was completed on August 23, 2003. Interview with the Registered Nurse (RN) on September 26, 2008 at 11:00 AM indicated that the Director of Nursing may have a copy of the X-ray results. Further record review and interview with the facility's RN on the same day at 1:55 PM, it was acknowledged that Client # 1's X-rays were not obtained as recommended by the physician.	W 325	W325 It is M.O.P policy that medical reviews be conducted on a monthly basis in an effort to ensure that all recommendations are implemented and followed-up on in a timely fashion. The RN did schedule the chest x-ray for resident # 1 to be completed on October 24, 2008. In the future, the RN will ensure timely follow-up of all recommendations and the status of these recommendations will be reflected in both the RN and QMRP notes.	10/24/08 and ongoing
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that each client received nursing services in accordance with their needs for one of two clients included in the sample. (Client #1) The findings include: 1. The facility's nursing staff failed to provide routine laboratory testing as determined	W 331		

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W 331	Continued From page 14 necessary by the physician for Client #1. [See W325] 2. The facility's nursing staff failed to ensure that nursing assessments included direct physical examination. [See W334] 3. The facility's nursing staff failed to ensure that each client's health status was reviewed by a registered nurse staff on a quarterly or more frequent basis. [See W336]	W 331	W 331 1. Resident #1 received routine lab work on 4/26/08, 7/19/08, and 9/6/08 (see attached lab results) In the future, the facility will continue to ensure that routine lab work is completed for each individual in a timely manner as determined necessary by the physician and appropriately filed in the individual medical record.	9/26/08 and ongoing
W 334	483.460(c)(3)(i) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be by a direct physical examination. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that nursing assessments included direct physical examination for two of the two clients included in the sample. (Clients #1 and #2) The findings include: 1. Review of Client #1 medical record on September 26, 2008 at 3:00 PM revealed a nursing assessment dated December 19, 2007 and monthly nursing progress notes for 2008. The monthly nursing progress notes included lab results, medical appointment, and blood pressure readings. The monthly nursing progress notes failed to provide evidence that quarterly nursing assessments included direct physical examination and checks of all the body systems.	W 334	2. As part of the future nursing monthly evaluation, physical assessment will be completed and results documented on the monthly report. In the future M.O.P complete a more thorough nursing monthly evaluations that encompass full system screenings. 3. M.O.P policy and procedures stipulates that nursing reviews are to be conducted on a monthly basis which is more frequently than quarterly. (In the future the facility will promote best practices by ensuring that the RN conducts systematic monthly reviews of each individual's health status. W334 1. As part of the nursing monthly evaluation a full system check will now be conducted. In the future M.O.P will complete thorough nursing monthly evaluations that encompass full system screenings.	9/26/08 and ongoing 9/26/08 and ongoing.

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W 334	Continued From page 15 Interview with the facility's Registered Nurse (RN) indicated that quarterly physical examinations were not required according to the Director of Nursing. 2. Review of Client #2 medical record on September 26, 2008 at 3:00 PM revealed a nursing assessment dated December 19, 2007 and monthly nursing progress notes for 2008. The monthly nursing progress notes included lab results, medical appointment, and blood pressure readings. The monthly nursing progress notes failed to provide evidence that quarterly nursing assessments included direct physical examination and checks of all the body systems. Interview with the facility's Registered Nurse (RN) indicated that quarterly physical examinations were not required according to the Director of Nursing.	W 334	2. M.O.P policy and procedures stipulates that nursing reviews are to be conducted on a monthly basis which is more frequently than quarterly. As part of the future nursing monthly evaluation a full system check will be conducted. In the future M.O.P will complete thorough nursing monthly evaluations that encompass full system screenings.	9/26/08 and ongoing.
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a health status was reviewed by the nursing staff on a quarterly or more frequent basis for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. Review of Client #2's medical record on September 26, 2008 at approximately 3:00 PM	W 336		

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W 336	Continued From page 16 revealed an annual nursing assessment dated December 19, 2008. Further review of the client's record revealed that there were no quarterly assessments in the record after the date annual assessment. Further interview with the Licensed Practical Nurse confirmed that the quarterly assessment had not been completed. 2. Review of Client #2's medical record on September 26, 2008 at approximately 12:00 PM revealed an annual nursing assessment dated January 22, 2008. Further review of the client's record revealed that there were no quarterly assessments in the record after the date annual assessment. [Cross Refer to W334]	W 336	W336 M.O.P policy and procedures stipulates that nursing reviews are to be conducted on a monthly basis which is more frequently than quarterly. In the future the M.O.P RN will completed a more thorough nursing monthly evaluation to encompass full system checks.	9/26/08 and ongoing
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive treatment services for the maintenance of dental health for one of the two clients in the sample. (Client #2) The findings include: Review of Client #2' s records on September 25, 2008 at 3:30 PM revealed Client #2 was seen by the dentist as documented below: October 12, 2006 - the dental consultant documented that the client had heavy calculus	W 356	W 356 Due to delay in receiving authorization from Medicaid, this appointment was delayed. However resident # 2 was recently seen by the dentist on 10/15/08 and it was recommended that the individual receive dental services from a dental surgeon. This recommendation has been forwarded to the Human Rights Committee and a message has been left for individual's sister to give consent. (See Attached Dental Evaluation Form) In the future, M.O.P will make every effort to have all medical appointments completed in a timely manner to and that these efforts are appropriately documented in the nursing monthly notes in an effort to ensure that all individuals are receiving optimal health services.	10/15/08 and ongoing

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W 356	Continued From page 17 deposits and needed scaling. January 22, 2008 - appointment cancelled by the residential provider. February 6, 2008 - the client refused treatment. March 17, 2008 - the dental consultant documented that the client had periodontitis, large build up plaque an calculus on all teeth. Surface gums bleed when touched. The dentist recommended full mouth scaling and polishing of all remaining teeth under deep conscious sedation. Interview with the Registered Nurse on September 26, 2008 and review of Client #2's medical record failed to provide evidence that the recommended dental services had been conducted.	W 356		
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to store drugs under proper conditions of security during administration. The finding includes: The facility failed to ensure that each client's medications were secured during administration. During the medication administration on	W 381	W381 On 10/19/08 the RN retrained all TME's on proper medication storage and appropriate medication delivery procedures. (See attached agenda and sign-in sheet) In the future the RN will closely monitor all TME's administering medication at least once a month and re-train as deemed necessary.	10/19/08 and ongoing

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W 381	Continued From page 18 September 24, 2008 at 5:20 PM, the trained medication employee (TME) was observed to leave the client's topical medication on the kitchen table between Clients #2 and Client #3. Client #1's routine medications were observed on the countertop while the TME went to the client's bedroom (located in the back of the house). Clients, staff and the surveyor were in the area when the medications were unsecured.	W 381		
W 383	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to have only authorized persons with access to the keys to the drug storage area. The finding includes: The facility nursing staff failed to ensure that only authorized personnel had access to clients medication. On September 24, 2008 at 4:50 PM, the trained medication employee (TME) Staff #8 was observed to open a file cabinet located in the kitchen, retrieve a key and open the medication cabinet. .On September 25, 2008 TME staff #7 was observed to open a file cabinet located in the kitchen, retrieve a key and open the medication cabinet. Interview with the QMRP and Registered Nurse (RN) on September 26, 2008 at 11:00 AM revealed that keeping the key in the file cabinet	W 383	W383 On 10/19/08 the procedures for access to the key for the medication cabinet was revised. Additionally all untrained staff has been signed up to receive TME certification on or before 12/15/08.	10/19/08 and ongoing

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W 383	Continued From page 19 was the system used to ensure access and availability for the TME's. The QMRP and RN agreed that the key was easily accessible for anyone entering the facility to gain unauthorized access to clients' medications. Review of the personnel files on September 26, 2008 revealed no evidence that all the direct care staff personnel had TME certifications.	W 383		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide a nourishing, well-balance diet for three of the three clients in the facility. (Clients #1, #2, and #3) The finding includes: On September 25, 2008 at 12:15 PM, Client #2 received bologna and cheese on wheat toast, applesauce with bananas, graham crackers, iced tea and water for lunch. On September 25, 2008 at 5:00 PM, direct care staff was observed preparing baked fish, baked macaroni and cheese, green beans and applesauce for dinner. Interview with the direct care staff indicated that substitutions were made for both meals because the food was not available in the facility. Review of the menu on September 26, 2008 at approximately 2:00 PM revealed that the lunch menu consisted of pasta salad, tuna with lettuce, fruit cup, mild graham crackers. Further review of the menu revealed that the dinner menu	W 460	W460 On 10/16/08 the QMRP has updated the menu book to reflect the appropriate substitution list and re-in serviced staff on the appropriate documentation of all menu substitutions (see attached sign-in, agenda and substitution form) In the future, the QMRP and Home Manager will monitor meal preparation on a weekly basis in an effort to ensure that the meal selection is in line with the menu and the Nutritionist will monitor quarterly.	10/16/08 and ongoing

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W 460	Continued From page 20 consisted of turkey tacos, corn on the cob, green beans, mandrin oranges, and a beverage. Review of the menu revealed no substitution list. Therefore, it could not be determined if the substitutions made for the planned menu items were of similar nutritional value.	W 460		

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I 000	INITIAL COMMENTS A recertification survey was conducted from September 24, 2008 through September 26, 2008. The survey was initiated using the full survey process. A random sample of three residents was selected from a population of six male residents with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and three day programs, interviews with residents and staff, and the review of clinical and administrative records including incident reports.	I 000	Received 10/21/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to maintained each resident's funds received and disbursed for one of the two residents in the sample. (Resident #1) The finding includes: Review of Client #1's financial record was conducted on September 26, 2008 at 1:00 PM. The bank statements were reviewed from December 2007 through July 2008 and revealed the following withdrawals: - July 14, 2008 in the amount of $118.17. There were receipts totaling 45.14; - July 18, 2008 in the amount of $25.00; and - July 21, 2008 in the amount of $34.00.	I 189	1189 M.O.P policy states that resident accounts are to be reconciled on a monthly basis. However due to the fact that the home manger was in a severe accident at the time of the survey, we were unable to obtain information about the missing receipts for the resident#1, during the month of July. In the future however all resident funds will be thoroughly and completely reconciled prior to the release of any additional monies and the financial records will be audited on Quarterly basis by the QMRP as part of her Quarterly review. (See attached financial policy)	11/15/08 and ongoing

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I 189	Continued From page 1 At the time of the survey, the facility failed to ensure a complete accounting of Client #1's personal funds by proving evidence that justified the aforementioned withdrawal.	I 189		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to achieve compliance with State regulations pertaining to health (22 DCMR Chapter 35, Section 3509.6). The finding includes: The State regulatory agency conducted a review of personnel records on September 25, 2008, at which time there was no evidence of current health certificates on file for Staff #1, Primary care physician, psychiatrist, behavior therapist, podiatrist and the registered nurse.	I 206	1206 On 9/26/08 the HR coordinator forgot to attach the physical exam documents for consultants. Current employment physicals are now in place. In the future these documents will be included with the consultant files.	9/26/08 and ongoing
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.	I 422		

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I 422	Continued From page 2 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide training and assistance to residents in accordance with the their Individual Habilitation Plans for one of the two residents included in the sample. (Resident #1) The finding includes: During the medication administration on September 24, 2008 at 5:02 PM, Resident #1 was observed punching medication from the bubble pack into a medication cup with physical assistance from the Trained Medication Employee (TME). The TME put the medication cup on the table. The resident was observed picking up the medication cup and water and drinking independently. Interview with the TME indicated that the resident participates well in the self medication program. Review of the Resident #1's Individual Program Plan (IPP) dated December 18, 2007 revealed a program objective which stated, "With staff assistance, [the resident] will review his list of medications and their purpose, weekly." There was no evidence that the resident listed his medications during the medication pass observation.	I 422	1422 On 10/19/08 the RN retrained all TME's on proper medication storage and appropriate medication delivery procedures, and implementation of medication goals. Additionally, on 10/17/08 the RN along with the input of direct care staff and the QMRP, has completed all self medication assessments for the individual's residing in the facility and subsequently developed appropriate goals based on the individual's level of independence. In the future the RN will closely monitor all TME's administering medication at least once a month and re-train as deemed necessary.	10/19/08 and ongoing
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan;	I 424		

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I 424	Continued From page 3 This Statute is not met as evidenced by: Based on observations, staff interviews and record review, the Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the resident has successfully completed an objective identified in the IPP for one of the two residents in the sample. (Resident #1) The finding includes: Review of Resident #1's IPP dated December 18, 2007 on September 25, 2008 at approximately 3:00 PM revealed a program objective which stated, "With staff assistance, [the resident] will exit the home in less than three minutes during a fire drill for four consecutive sessions". Review of the QMRP quarterly review dated July 10, 2008 revealed that the resident met the established criteria for the period of April 2008 through June 2008. Further review of the data sheets indicated that the resident met the established criteria since May 2008. There was no evidence that the QMRP revised the program.	I 424	1424 Based on information gathered from the program data sheets for resident# 1, he has met the criteria of exiting the home with staff assistance in less than three minutes during a fire drill for four consecutive sessions. However the QMRP decided to continue this goal for maintenance and modify the completion date to twelve months rather than four in order to ensure that the individual is able to meet complete this task in times of emergencies. In the future the QMRP will ensure that all program outcomes are monitored monthly and updated or revised based on achievement o f goals to promote maximum independence	11/20/08 and ongoing
I 432	3521.7(c) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure residents	I 432		

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	HFD03-0228	A. BUILDING _____ B. WING _____	09/26/2008

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I 432	Continued From page 4 were effectively trained in toothbrushing for one of the two residents included in the sample. (Resident #2) The finding includes: Observations on September 24, 2008 at 5:45 PM, Resident #2 completed his dinner. The resident propelled his wheelchair to the living room where he watched television until 6:45 PM. Review of Resident #2's medical record revealed a dental consultation dated March 17, 2008 and October 12, 2006. The consultation indicated that the resident had periodontitis disease, heavy plaque and calculus deposits. The dentist recommended that the resident brush his teeth three times per day (after each meal). There was no evidence that the direct care staff encouraged the resident to brush his teeth. Review of the IPP dated November 18, 2007 failed to identified a toothbrushing program.	I 432	1432 On 10/19/08 the QMRP has implemented a hygiene monitoring program to promote optimal oral health for all individuals in the home. The QMRP has trained staff on the implementation and documentation of the program and will monitor data and implementation on a weekly basis. In the future the QMRP will ensure that all specialist recommendations are immediately followed-up on and implemented to promote optimum health. (See attached Hygiene Maintenance Chart, training sign-in sheet and agenda)	10/19/08 and ongoing
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide training and assistance to residents in accordance with the resident's Individual Habilitation Plan for one of the two residents included in the sample. (Residents #2	I 436		

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I 436	Continued From page 5 and #3) The finding includes: During the medication administration on September 24, 2008 at 5:02 PM, Resident #1 was observed punching medication from the bubble pack into a medication cup with physical assistance from the Trained Medication Employee (TME). The TME put the medication cup on the table. The resident was observed picking up the medication cup and water and drinking independently. Interview with the TME indicated that the resident participates well in the self medication program. Review of the Resident #1's Individual Program Plan (IPP) dated December 18, 2007 revealed a program objective which stated, "With staff assistance, [the resident] will review his list of medications and their purpose, weekly." There was no evidence that the resident listed his medications during the medication pass observation.	I 436	1436 On 10/19/08 the RN retrained all TME's on proper implementation of medication goals. Additionally, on 10/17/08 the RN along with the input of direct care staff and the QMRP, has completed all self medication assessments for the individual's residing in the facility and subsequently developed appropriate goals based on the individual's level of independence. In the future the RN will closely monitor all TME's administering medication at least once a month and re-train as deemed necessary.	10/19/08 and ongoing
I 439	3521.7(i) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (i) Home management (including maintenance of clothing, shopping, meal planning and preparation, and housekeeping); This Statute is not met as evidenced by: Based on iterview and record review, the GHMRP failed to ensure IPP objectives were developed to teach residents how to prepare meals for one of the two residents in the sample (Resident #1)	I 439		

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I 439	Continued From page 6 The finding includes: On September 24, 2008, at 4:20 PM, a direct care staff was observed preparing dinner. At 5:35 PM, the direct care staff was observed putting the dishes in the dishwasher after the dinner. Resident #1 was observed going to the living room area and having a seat on the sofa. Interview with the direct care staff indicated that Resident #1 does not participate in meal preparations or clean up. Review of the resident's Nutritional assessment dated December 18, 2007 on September 25, 2008 at 3:30 PM revealed a recommendation for the resident to participate in meal preparation. Further review of the resident's IPP dated December 18, 2007 failed to identify a meal preparation program.	I 439	1439 On 10/19/08 the QMRP has implemented a meal preparation program for individual #1 as well as #2 based on their level of independence. Additionally, the QMRP on 10/19/08 has conducted trainings on implementation and documentation of these new programs. In the future, the QMRP will continue to assess individual's strength by completing ABS-RC2 assessments annually, and accordingly develop activities and programs that promote independence and positive outcomes for each resident.	10/19/08 and ongoing
I 441	3521.7(k) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (k) Mobility (including ambulation, transportation, mapping and orientation, and use of mobility equipment); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure the habilitation of its residents included training in the area of mobility for one of the two residents in the facility. (Resident #1) The finding includes: On September 24, 2008 at 4:10 PM, Resident #1	I 441		

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I 441	Continued From page 7 arrived home from day program in a wheelchair. At 4:15 PM, a direct care staff was observed removing the resident's shoes. At 4:18 PM, the resident was observed walking to his bedroom using a roller walker. The resident's feet were observed in a horizontal position. Interview with the direct care staff indicated that once the resident came home from day program he utilized his roller walker around the house. Review of Resident #1' s record on September 25, 2008 at approximately 3:00 PM revealed a Physical Therapy (PT) assessment dated December 12, 2007. According to the assessment, the consultant recommended that the resident should wear shoes during "ALL" ambulation. Further interview with the direct care staff indicated that the resident usually refused to walk in his shoes. Interview with the Qualified Mental Retardation Professional (QMRP) on September 25, 2008 verified the information documented by the consultant and indicated that the resident should wear shoes during all ambulation. At the time of the survey, the facility failed to ensure staff kept shoes on Resident #1 during ambulation as recommended by the PT.	I 441	1441 Resident#1 has expressed discomfort when ambulating with shoes around the house. As a result the PT has re-evaluated the individual to ensure safety if he desires to ambulate without his shoes in the home. (See attached PT report) In the future however, the QMRP will staff appropriately implements all programs by conducting weekly systematic monitoring and training of staff implementation of IPP goals and recommendations to ensure appropriate support is being given to the individual to achieve maximum outcomes. In cases where there is concern about the implementation of the recommendations, the QMRP will notify the professional that developed the program within 72 hours to request a reevaluation or modification as deemed necessary.	10/4/08 and ongoing
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each resident rights for two of the	I 500		

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I 500	Continued From page 8 two residents included in the facility. (Residents #1 and #2) The findings include: 1. The facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment. [See W124] 2. The facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained. [See W263]	I 500	1500 1. As of 10/2/08 M.O.P has revised its policy to ensure that all procedures requiring sedation are preceded by consent from the individual's legal guardian. In the future, M.O.P will ensure that consents are received prior medical appointments and that the consents are maintained in the individual's medical record. (See attached revised policy 2. On 10/20/08 a copy of the M.O.P policy which specifically details to procedures for obtaining consent prior to all appointments requiring sedation has been distributed to all members of the HRC committee. In the future the HRC will ensure that all guidelines are adhered to prior to approval any planning consisting of sedation procedures.	10/2/08 and ongoing 10/20/08 and ongoing

Health Regulation Administration

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R 000	INITIAL COMMENTS A recertification survey was conducted from September 24, 2008 through September 26, 2008. The survey was initiated using the full survey process. A random sample of three residents was selected from a population of six male residents with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and three day programs, interviews with residents and staff, and the review of clinical and administrative records including incident reports.	R 000	Received 10/21/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. The finding includes: Review of the personnel files on September 25, 2008 revealed the GHMRP failed to provide evidence of criminal background checks for five	R 125	R125 On 9/26/08 updated background checks have been completed for all staff in the facility. In the future the Human Resources coordinator will audit all personnel files at least annually to ensure that all requirements including background checks and current health certificates are present in all personnel files.	9/26/08 and ongoing

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R 125	Continued From page 1 direct care staff (Staff #2, #4, #5, #6, and #7).	R 125		